from point to point. Stacked cumulative percent plots can be applied to diverse disease types and to outcomes with varying amounts of anticipated change from point to point.

**PMC3**

**USING FRONTIER ANALYSIS TO OPTIMIZE THE OVERALL LIFE YEARS GAINED IN VACCINATION POLICY OF INFECTIOUS DISEASES**

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**OBJECTIVES:** The aim of the study is to utilize the novel frontier analysis to search for optimal strategy of vaccination policy against infectious diseases with limited vaccine supply. **METHOD:** An important goal of public health research is to predict clinical impact by nation-wide mass vaccination in preventing infectious diseases. Vaccination is usually given across potential vulnerable populations such as children. However, due to limited resources provided by the government among a growing number of competing vaccine products, some vaccinations are to be given to some targeted high-risk cohorts against infectious diseases, such as pneumonia or influenza. Hence, the optimal strategy of vaccination policy for effective disease control becomes a practical concern. We propose a model using frontier analysis to seek the optimal vaccination policy in controlling infectious disease epidemics. This versatile model can forecast: long-term relationships emerge between any of the instruments of control and costs and utilities, to seek the optimal vaccination policy in controlling infectious disease epidemics.

**PMC4**

**A FRAMEWORK FOR DEVELOPING A FLEXIBLE CONTROL-BASED ASTHMA POLICY MODEL**

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**OBJECTIVES:** The goal of asthma management is to gain and maintain control. Several validated patient-reported measures are available to assess the degree of control: Asthma Control Questionnaire (ACQ), Asthma Control Test (ACT), and the Asthma Therapy and Assessment Questionnaire (ATAQ). We propose a flexible and transparent model framework that represents disease variability through exacerbation rates and any one of the three control instruments. **METHODS:** We developed a Markov model to simulate cohorts transitioning among six health states: an asthma control continuum state (variability in control is tracked using one of the three control instruments), the severity levels of asthma exacerbations, and asthma and non-asthma related death. To estimate the cost and outcome weights for the control continuum state, we explored the relationship between the ATAC (higher ATAC = less control) and management costs (including absenteeism costs) and utilities using a large asthma registry of exacerbation-free patients. A hypothetical asthma intervention adds an additional standard-of-care was compared to standard-of-care alone as summarized by the following product profile: a 50% reduction in asthma exacerbation rates, a 0.5 absolute improvement in the ATAC score, and an additional $10,000 per annum intervention cost. **RESULTS:** The estimated change in bi-weekly asthma management costs for a one unit increase in the ATAC score was $16.12 (robust SE = $3.95) and for utilities was $0.05 (robust SE = 0.0041). Assuming a five year time horizon, the hypothetical intervention plus standard-of-care had an incremental mean cost of $25,800 (95% interval $16,600, $44,000), quality adjusted life year (QALY) of 0.257 (0.253, 0.261), and cost per QALY of $100,350/QALY ($13,700, $199,800). **CONCLUSIONS:** As relationships emerge between any of the instruments of control and costs and utilities, this versatile model can forecast: long-term burden of disease, value of existing and emerging interventions, and inputs that yield the highest return from further study.

**PMC7**

**EFFECTS OF HETEROGENEITY ON THE ESTIMATION AND COMPARISON OF MEDICATION ERROR RATES**

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**OBJECTIVES:** The clinical consequences and costs of medication errors (ME) have significant implications on quality of care. A detailed understanding of the occurrence and patterns of MEs is critical to reducing ME rates and improving patient outcomes. However, ME rates are often estimated inaccurately. ME rates are typically heterogeneous with respect to hospitals and units within hospitals, because of differences in health care provider (HCP) experience and skill. Although this heterogeneity has important implications for the precision and power of ME analysis, it is seldom taken into account in the estimation of MEs. **METHODS:** To evaluate the effects of heterogeneity on the precision and power of estimated ME rates, we assumed three sources of heterogeneity: hospital, unit (or HCP) within hospital, and random error. We derived formulas representing the variances of the estimated ME rates and the variances of comparisons of ME rates, and graphically illustrated the effects of sample sizes and magnitudes of heterogeneity on the variances. **RESULTS:** The heterogeneity associated with hospital and unit induces clustering of MEs within hospitals and units, increasing variability in the estimated ME rates compared with what would be observed in the absence of heterogeneity. Even in the presence of low levels of heterogeneity, the variances of the estimated ME rates can be substantially increased. **CONCLUSIONS:** The heterogeneity associated with comparisons of ME rates also can be substantially affected with decreased power for comparisons between hospitals or units and increased power for comparisons within hospitals or units. **CONCLUSIONS:** Heterogeneity of MEs with respect to hospitals and hospital units (or HCPs) can have a substantial effect on precision and power, and should be incorporated in the analyses ME rates. We provide precision and power formulas for planning future studies of MEs.